Montana Health Care Programs
Medicaid ● Mental Health Services Plan ● Healthy Montana Kids
Individual Adjustment Request

Instructions:
This form is for providers to correct a claim which has been **paid** at an incorrect amount or was **paid** with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete **only** the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information for Providers* manual, or call Provider Relations at (800) 624-3958 (Montana and out-of-state providers) or (406) 442-1837 (Helena).

A. Complete all fields using the remittance advice (RA) for information.

1. Provider Name and Address

Fred Flinstone
Name

123 Main Street
Street or P.O. Box

Somewhere **MT** **59601**
City State ZIP

2. Client Name

Kid Smith

3. Internal Control Number (ICN)

21200000000000200

4. NPI/API

1234567890

5. Client ID Number

5555555

6. Date of Payment **06 01 2012**

7. Amount of Payment $ **250.00**

B. Complete only the items which need to be corrected.

Item	Date of Service or Line Number	Information on Statement	Corrected Information
1. Units of Service	**05 01 12**	**5**	**3**
2. Procedure Code/NDC/Revenue Code			
3. Dates of Service (DOS)			
4. Billed Amount			
5. Personal Resource (Nursing Facility)			
6. Insurance Credit Amount			
7. Net (Billed – TPL or Medicare Paid)			
8. Other/Remarks (Be specific.)			

Signature Suzy Q Date **07 01 2012**

When the form is complete, attach a copy of the RA and a copy of the corrected claim, and mail to:

Claims
P.O. Box 8000
Helena, MT 59604

Updated 07/2012